Review of Specified Disease Insurance Policies

subject to M.G.L. c. 175, c. 175I and c. 176, where applicable, as well as 211 CMR 42.00 and 211 CMR 146.00, where applicable

Insurer _____ NAIC # _____

Name of Plan, Form # _____

Contact person, Title _____

Address _____

Telephone _____ Fax _____

E-mail address _____

Date received _____ Reviewed by _____

$75 form filing fee processed on _____ *801 CMR 4.02(21); SRB #*_____

$150 rate filing fee processed on _____ *801 CMR 4.02(30); SRB #*_____

This represents the checklist tool used by State Rating Bureau ("SRB") analysts to review policies according to the minimum standards identified in relevant statutes and regulations. The filing will not be considered complete for purposes of *M.G.L. c. 175 §193F* until all the required items or certifications have been received in the SRB.

Pursuant to Bulletin 2001-05, this checklist is required to be submitted when filing specified disease insurance policy form(s), whether submitted as a new form or as a revision to an existing form.

Next to each item on the checklist, indicate the page number and/or section where the noted item is described within the filed form(s) to assist the State Rating Bureau analyst in locating the section of the filing addressing the checklist item.

- **If an item is not applicable to a company filing, please note "N/A" next to the item on the checklist and explain in your letter why the item is not applicable to the filing.**
- **If an item only requires confirmation that the company complies with particular statutory or regulatory requirements, please place a checkmark next to the item certifying company compliance with the item.**

Filings that do not include a properly completed checklist will be returned and not reviewed.

Policy Forms

General Requirements

___ Filing is for ____ individual policy, ____ employer-based group policy OR ___ group trust/association policy
___ If an individual policy, it will be offered through____ worksite enrollments OR ____ face-to-face agent contacts
___ Please confirm that the filing includes a certification that it does not contain any provision that is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy, and that benefits must be reasonable in relation to the premium charged. *M.G.L. c. 175, § 108 8.A*
___ Please confirm that each form submitted for final approval is printed, is a printer's proof, or be in the form in which it will be issued. If more than one company uses the same forms, each company's forms must be submitted separately on its own letterhead.
___ Please confirm that the following forms are included and identify the unique identifier for each form:
- ___ Policy _____
- ___ Policy Disclosure Form _____
- ___ Outline of Coverage _____
- ___ Medicare disclosure notice (211 CMR 42.09(4) _____
- ___ Application _____
- ___ Notice of Information Practices _____
- ___ Replacement form _____

___ The policy, riders and all amendments, as well as the application, outline of coverage and other required disclosure materials distributed to any potential applicant must be presented in no less than 10-point type as well as satisfy the readability standards of M.G.L. c. 175 § 2B. *211 CMR 146.10(2)a.*
___ Filing includes certification by company official that each form meets standards of M.G.L. c. 175 §2B. If insurer feels that any form is exempt from M.G.L. c. 175 §2B, letter should state reason for exemption. The term "text" includes all printed matter except the name and address of the insurer, name or title of the policy, captions and subcaptions, and schedule pages and tables used in the policy. *M.G.L. c. 175 §2B*
- ___ Text of each form achieves minimum Flesch score of 50 as stated in certification. (A statement to the effect that the score exceeds 50 is not permitted.)
- ___ a. It is printed, except for tables, in not less than ten-point type, one point leaded.
- b. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy and any endorsements or riders;
- c. It contains a table of contents or an alphabetical subject index;
- d. The width of margins and ink to paper contrast do not interfere with the readability of the form; and
- e. The organization of the content of the policy and the summary of the policy are conducive to understandability of the form.

___ If a policy has a specification page, it should provide the following information:
- ___ Policy number ___ Name of insured ___ Other persons covered at issue date
- ___ Effective date ___ Listing of the premium or premiums payable and the periods to which they apply
- ___ Lists, with cost, if any, of each exclusionary waiver and of each premium-bearing rider or endorsement. Unless the insured has given a signed acceptance, the listing shall also include a brief description of each.

___ Each form must contain a form number on the lower left-hand corner of the cover page OR on the first page of the form if the form number would be visible with the cover closed. *M.G.L. c. 175, § 108 2.(a)(6)*
___ All policies and contracts must be headed by the corporate name of the company. If two or more insurers are under a common management and represent themselves to be or are customarily known as an insurance company group or similar insurance trade designation, they may, with the approval of the commissioner, head or title policies with the name of the group or similar trade designation or with the names of the individual members of the group, provided that the company assuming the insurance is specifically identified. *M.G.L. c. 175, §18*
___ All policies shall be signed by its secretary or an assistant secretary, or in their absence by a temporary secretary, and by its president or a vice-president, or in their absence by two directors. Riders or endorsements may be signed by one of the aforesaid officers of the company. A facsimile of the required signature is acceptable. *M.G.L. c. 175, §33*

Rate Filing

___ A rate filing must be enclosed with each policy, rider, or endorsement that affects the premium rate to be charged. *211 CMR 42.06(2)*

___ All rate filings shall at least explain formulas used to derive rates, expected claim costs, assumptions regarding mortality, morbidity and lapse rates, and the detailed commission schedule and anticipated administrative expenses associated with the policy. In order to substantiate rate revision filings, filings must maintain experience for that policy form, may combine experience for different policy forms where the coverage is substantially the same, and must demonstrate that the carrier is using fund accounting for guaranteed renewable policies to reflect premiums, investment income, losses, expenses, and provisions for reserves specific to that policy form.

___ Any rates filed, whether initial or revised, will be disapproved unless the aggregate anticipated loss ratio for the entire period for which rates are computed to provide coverage meets the loss ratio standard for the policy. and for specified disease policies, whether the filing is for an initial or revised rate, the minimum loss ratio shall be no less than 60% for individual policies; any rate filing for a specified disease insurance policy shall state the carrier's Expected Durational Loss Ratios that will be used in completing future experience monitoring forms described in 211 CMR 146.102. *211 CMR 42.06(2)*

___ Every carrier must maintain on file with the Division an up-to-date rate manual for all individual accident and health policies, riders, and endorsements currently available for sale in Massachusetts, that must include: (a) name of carrier on each page, (b) table of contents or index, and (c) identification by form number of each policy or endorsement to which the rates apply. *211 CMR 42.06(4)*

___ The rate filing specifies the rates to be charged to all underwriting classes in a way that makes clear how the rates will be applied to any occupation, actual or expected health condition, claims experience, duration of coverage or medical condition of a covered person. *211 CMR 146.08(3)*

___ All rate filings are subject to review by an actuary specified by the Commissioner whose costs will be paid by the company submitting the filing. Filing is to include certification from company's Chief Financial Officer that all actuarial costs associated with reviewing the filing will be borne by the company as part of the filing. . *211 CMR 42.06(3)(a)*

Cover Page

___ Company name, address and phone number are listed.
___ The following statement must appear in 14-point boldface type: "Notice to buyer: This insurance provides a limited benefit in the event you are diagnosed with [the specified disease or diseases]. This policy is a supplement and not a substitute for a health benefit plan. You must have a health benefit plan in order to purchase this insurance. " *211 CMR 146.10(1)a.*
___ A section in boldface type highlighted on the first page of the policy must either list all pre-existing condition exclusions or limitations or refer the individual to the section within the policy that lists all pre-existing condition exclusions or limitations. *211 CMR 146.10(1)b.*
  ___ If a plan has a pre-existing condition limitation,
    ___ the pre-existing condition limitation is for no more than a six-month period. *211 CMR 146.05(5).*
    ___ the pre-existing condition may only apply to a condition for which medical advice was given or treatment was recommended by, or received from, a licensed health care provider within the six (6) month period immediately preceding the effective date of the coverage. *211 CMR 146.05(5).*
    ___ this limitation shall appear as a separate paragraph in the policy and shall be labeled as "Pre-Existing Condition Limitations." *211 CMR 146.05(5).*
___ A renewability section notice must clearly identify whether the policy is noncancelable or guaranteed renewable, and whether it is being issued on other than an individual basis (policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage shall be on the policy form then being issued by the carrier for this purpose). *211 CMR 146.10(1)c.*
___ The policy clearly describes whether it is an individual or group policy *211 CMR 146.09(3)*

***Questions re cover page**:*

Definitions

All definitions used in the policy must conform to the definitions in 211 CMR 146.04

___ Definitions should be in alphabetical order for ease of disclosure and comparison with other policies.
___ All terms used in the policy must be fully explained so that the insured understands their relationship to the benefits covered. *211 CMR 146.10(2)a.*
___ All definitions used in the policy must conform to the definitions in *211 CMR 146.04*, *i.e.,* they must be substantially the same.

___ Guaranteed renewable means the policy feature that guarantees the insured's right to continue the in-force insurance policy by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, and cannot make any unilateral change in any provision of a guaranteed renewable coverage without the agreement of the insured, but on a class basis, the carrier may revise premium rates for guaranteed renewable policies subject to the approval of the commissioner.

___ Noncancelable means the policy feature that guarantees the insured's right to continue the in-force insurance policy at the same premium level by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, cannot make any unilateral change in any provision of coverage, and cannot revise premium rates for a noncancelable policy without the agreement of the insured.

___ Pre-existing condition means a medical condition for which an insured received diagnosis or treatment during the 6-month period prior to the effective date of coverage.

___ Specified disease coverage means a policy which pays benefits on an indemnity or lump sum basis for the diagnosis and/or treatment of the disease or diseases specifically names in the policy which can be life threatening in nature and could cause a person to incur substantial financial out-of-pockets expenses for the diagnosis and/or treatment of the specifically named disease or diseases.

Although the following definitions are not required to be in a policy, when used by a company in its policy, the terms should represent the following definitions as included in 211 CMR 1146.04:

___ Employment-Based Group Policy means a certificate issued to an insured who is enrolled in a group policy issued to one or more employers or labor organizations, or to the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

___ Group Policy means the certificate issued to an insured who is enrolled through a group trust or association to which the carrier has issued a specified disease insurance policy. For the purposes of 211 CMR 146.00, this does not include an employment-based group policy.

___ Individual Policy means a policy issued by a carrier directly to an insured.

Questions re definitions:

Benefits

These are **minimum** standards (insurers may broaden the benefit offered)

Mandatory provisions:

___ Does the policy include a statement that it will cover all forms of the disease or diseases that are specified in the policy? . *211 CMR 146.05(1).*

___ Does the individual specified disease policy condition payment upon pathological diagnosis of a covered disease? ____ Yes or ____ No. *211 CMR 146.05(2)*.
If Yes, the policy shall include a provision that states that if a pathological diagnosis is medically inappropriate or life threatening, the carrier will accept a clinical diagnosis in lieu of a pathological diagnosis. *211 CMR 146.05(1).*

___ The policy includes a provision indicating that except for policy provisions regarding other specified disease coverage with the same insurer, the policy will pay benefits for specified disease coverage regardless of other coverage the insured may have. *211 CMR 146.05(4)* [This may be added to a policy provision addressing "Other Insurance in This Insurer"; see M.G.L. c. 175 § 108, 3.(b)(3)]

___ The following language, or language substantially similar to the following, must appear conspicuously on the policy, as well as the outline of coverage, at the time of delivery [Note: this does not apply if the policy is guaranteed issue.]:
"Caution: The issuance of this specified disease insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers were incorrect or untrue as of the date you signed the application, the carrier has the right to deny benefits or rescind your policy subject to the [time limit on certain defenses, incontestable] section of your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the carrier at this address: [insert address]." *211 CMR 146.11(3)b*

___ Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. Any rider that reduces benefits requires a signed acceptance by the policyholder or certificateholder. *211 CMR 146.10(2)(b); 211 CMR 42.09(2)*

___ Please confirm that the policy does not provide for a reduction of benefits upon the attainment of any age or condition. *211 CMR 146.05(6).*

Minimum Benefits When Policies Written on Indemnity or Recurring Basis

___ The policy includes a provision making clear that it shall provide benefits to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s) directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s)." *211 CMR 146.06(1).*

___ Does the policy condition any policy payments upon
____ a covered person receiving medically necessary care or treatment? *211 CMR 146.06(2)*
____ care or treatment is given in a medically appropriate location? *211 CMR 146.06(2)*
____ care or treatment is provided under a medically accepted course of diagnosis or treatment?
If the answer to any of the above item is yes,
Is this affirmatively and clearly stated in the policy?_____ *211 CMR 146.06(2)*
Is the carrier accredited according to M.G.L. c. 176O?_____ *211 CMR 146.06(2)*

___ Does the policy contain a waiting period? ____
If the answer is yes, where is it noted that the waiting period no more than for a 30-day period? *211 CMR 146.06(3)*
The policy shall include a provision indicating that for a specified disease diagnosed within the initial 30 days of coverage, the policy or certificate is either void from its beginning with a full premium refund to the insured, or the coverage for such diagnosed specified disease is subject to a pre-existing condition limitation not exceeding six months from the coverage effective date. The provision shall also indicate that the insured must elect whether the policy or certificate is to be voided with a full premium refund or coverage is to be delayed. *211 CMR 146.06(3)*

___ If the policy does not contain a waiting period or pre-existing condition limitation, the policy's benefits shall begin at least with the first day of medical care or hospital confinement for a covered disease, even though the diagnosis may be made at a later date. *211 CMR 146.06(4).*

___ Does the policy include benefits for confinement in a skilled nursing home or for home health care? ____

If yes, the coverage must equal a fixed sum payment of at least one-half of the hospital confinement inpatient benefit for each day of skilled nursing home confinement for at least 100 days, and a fixed sum payment of at least one-half of the hospital confinement inpatient benefit for each day of home health care for at least 100 days. *211 CMR 146.06(5).*

___ A provision shall note that if benefits are not payable for a period of 180 days, then a covered person shall be entitled to a new benefit period. *211 CMR 146.06(6).*

Minimum Benefits When Policy Benefits are for a Lump-Sum Payment for the Diagnosis of a Specified Disease Without Further Coverage for Treatment of that Disease

___ The policy is only offered with face value amounts in even increments of $1,000 and with benefits not to exceed $500,000 *211 CMR 146.07(1).*

___ Does the policy contain a waiting period? ____

If the answer is yes, where is it noted that the waiting period no more than for a 30-day period? *211 CMR 146.07(2)*

The policy shall include a provision indicating that for a specified disease diagnosed within the initial 30 days of coverage, the policy or certificate is either void from its beginning with a full premium refund to the insured, or the coverage for such diagnosed specified disease is subject to a pre-existing condition limitation not exceeding six months from the coverage effective date. The provision shall also indicate that the insured must elect whether the policy or certificate is to be voided with a full premium refund or coverage is to be delayed. *211 CMR 146.07(2)*

___ Indemnity amounts for any one specified disease cannot be required to be paid in more than two equal installments for any reoccurrences or spread of the same specified disease or a new primary occurrence of the same specified disease or the resulting death of the insured due to the same specified disease. *211 CMR 146.07(3).*

___ New waiting periods for any one specified disease cannot be instituted for any reoccurrences of spread of the same specified disease or a new primary occurrence of the same specified disease. *211 CMR 146.07(4).*

___ Benefit amounts payable for any one specified disease can be subject to a maximum policy benefit for all specified diseases covered under the policy. *211 CMR 146.07(5).*

___ A benefit shall always be payable upon initial and medically appropriate diagnosis of the specified disease covered by the policy and there shall not be any requirement that the insured survive for any period of time in order for the benefit to be payable. *211 CMR 146.07(6).*

Limitations and Exclusions

Does the policy limit coverage for pre-existing conditions?

__ yes ___ no

If yes:

___ Pre-existing condition limitations must be identified on the front of the policy and the outline of coverage. *211 CMR 146.10(1)b.*

___ Pre-existing condition limitations may not apply for more than a six-month period from the effective date of the policy. *211 CMR 146.05(5)*

___ The policy must include a provision that if the insurer denies liability and refuses to make payment on the basis of a pre-existing condition, the insurer shall transmit to the insured together with the notice of denial of liability documented evidence of specific instances of actual treatment or observation of such pre-existing condition, illness or injury in all cases except those of a confidential nature. *M.G.L. c. 175, § 108 2.(a)(2A)*

___ Individual policies may include limitations or conditions provided that they are clearly identified in a separate section of the policy. Such limitations may include, but are not limited to, illnesses, treatments or conditions arising out of the following circumstances:

1. war or act of war (whether declared or undeclared);
2. participation in a felony, riot or insurrection;
3. service in the armed forces or units auxiliary thereto;
4. attempted suicide or intentionally self-inflicted injury;
5. services provided for alcohol or drug detoxification;
6. aviation (this exclusion applies only to non-fare paying passengers);
7. services for which benefits are payable under Medicare, any state or federal workers' compensation program, employer's liability or occupational disease law, or any motor vehicle no-fault law;
8. services provided by members of the insured's immediate family; or
9. services for which no amount is normally charged in the absence of insurance.

Uniform Provisions - Compliance with M.G.L. c. 175 § 108, 3.(a)

Under section 3.(a) of section 108, each policy must contain the following provisions in the words in which they appear; provided, however, that the insurer may substitute for one or more of such provisions corresponding provisions of different wording which are in each instance not less favorable in any respect to the insured. The provisions must be preceded by an appropriate caption at the beginning of each item or group of items.

___ **Entire Contract; Changes**

This policy, including endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. *M.G.L. c. 175, § 108, 3.(a)(1)*

___ **Time Limit on Certain Defenses**

After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability as defined in the policy commencing after the expiration of such two-year period OR

Incontestable

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy. *M.G.L. c. 175, § 108, 3.(a)(2)*

___ **Grace Period**

A grace period of [insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies] days will be granted for the payment of each premium falling due after the first premium during which grace period the policy shall continue in force. *M.G.L. c. 175, § 108, 3.(a)(3)*

___ **Reinstatement**

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as many be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty, or, in the case of a policy issued after age 44, for at least five years from its date of issue.) *M.G.L. c. 175, § 108, 3.(a)(4)*

___ **Notice of Claim**

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at [insert the location of such office as the insurer may designate for the purpose] or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. *M.G.L. c. 175, § 108, 3.(a)(5)*

___ **Claim Forms**

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made. *M.G.L. c. 175, § 108, 3.(a)(6)*

___ **Proof of Loss**

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. *M.G.L. c. 175, § 108, 3.(a)(7)*

___ **Time of Payment of Claims**

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid [insert period for payment which must not be less frequently than monthly] and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. *M.G.L. c. 175, § 108, 3.(a)(8)*

___ **Payment of Claims**

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the beneficiary or to such estate. All other indemnities will be payable to the insured.

The following two paragraphs, or either of them, may be added to this provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding [insert an amount which shall not exceed $1,000], to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the services be rendered by a particular hospital or person. *M.G.L. c. 175, § 108, 3.(a)(9)*

___ **Physical examinations**

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder. *M.G.L. c. 175, § 108, 3.(a)(10)*

___ **Legal actions**

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of such loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. *M.G.L. c. 175, § 108, 3.(a)(11)*

___ **Change of beneficiary**

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries or to any other changes in this policy. *M.G.L. c. 175, § 108, 3.(a)(12)*

Optional Provisions - Compliance with M.G.L. c. 175 § 108, 3.(b)

Section 3.(b) of section 108 provides mandatory language for policies that include these provisions: *i.e.,* policies do not have to contain these provisions, but if they do, they must be in substantially similar language ("which [is] in each instance not less favorable in any respect to the insured or the beneficiary"). The provisions must be preceded by an appropriate caption at the beginning of each item or group of items.

___ **Misstatement of Age**

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age. *M.G.L. c. 175, §108 3.(b)(2)*

___ **Other Insurance in This Insurer**

If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for [insert type of coverage or coverages] in excess of [insert maximum limit of indemnity or indemnities] the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

OR

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies. *M.G.L. c. 175, §108 3.(b)(3)*

___ **Insurance with Other Insurers**

If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the like amount of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the above policy provision is included in a policy which also contains the next following policy provisions there shall be added to the caption the phrase -- EXPENSE INCURRED BENEFITS. The insurer may, at its option, include in this provision a definition of other valid coverage, approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities or this or any other state of the United States or any province of Canada, and by hospital or medical services organizations, and to any other coverage the inclusions of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying this policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute including any workmen's compensation or employer's liability statute whether provided by a governmental agency or otherwise shall in all cases be deemed to be other valid coverage of which the insured has had notice. In applying said policy provision no third party liability coverage shall be included as other valid coverage. M.G.L. c. 175, §108 3.(b)(4)

___ **Insurance with Other Insurers**

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under the policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

If this policy provision is included in a policy which also contains the above policy provision there shall be added to the caption of this provision the phrase - OTHER BENEFITS. The insurer may, at its option, include in this provision a definition of other valid coverage, approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law of by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying this policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute including any workmen's compensation or employer's liability statute whether provided by a governmental agency or otherwise shall in all cases be deemed to be other valid coverage of which the insurer has had notice. In applying this policy provision no third party liability coverage shall be included as other valid coverage. *M.G.L. c. 175, §108 3.(b)(5)*

___ **Unpaid Premium**

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom. *M.G.L. c. 175, §108 3.(b)(7)*

___ **Conformity with State Statutes**

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes. *M.G.L. c. 175, §108 3.(b)(9)*

___ **Illegal Occupation**

The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation. *M.G.L. c. 175, §108 3.(b)(10)*

Policy Disclosure Form

___ The policy disclosure form is a document separate from the policy, but may be combined with the outline of coverage. *211 CMR 146.10(3)*

___ Please indicate how the policy disclosure form will be delivered to applicants.

___ in the case of face-to-face meetings between an agent and potential insured, carrier or its agent will deliver the policy disclosure form prior to the presentation of the application or enrollment form

OR

___ in the case of direct response sales, or enrollment by telephone, internet or self-enrollment as part of an employee benefits package, the carrier must deliver the forms at the time the application or enrollment form is sent to the potential insured. *211 CMR 146.10(3)*

___ The policy disclosure form must be substantially similar to the one that follows; however, text that is capitalized or underlined may be emphasized by other equivalent means. *211 CMR 146.10(3)* and *211 CMR 146.100(1)*

COMPANY NAME

SPECIFIED DISEASE COVERAGE ONLY

REQUIRED DISCLOSURE STATEMENT

This policy or certificate is (an individual policy of insurance) (a group policy or certificate). This policy or certificate provides specified disease coverage ONLY. This policy or certificate does NOT provide basic hospital, basic medical or major medical insurance. It is a supplement to your health benefit plan and cannot replace your health benefit plan.

(Accurately list benefits, exclusions, reductions and limitations of the policy or certificate in a manner which does not encourage misrepresentation of the actual coverage provided.)

This disclosure statement is a very brief summary of your policy or certificate.

The policy or certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR POLICY OR CERTIFICATE carefully.

The expected benefit ratio for this policy or certificate is ___%. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy or certificate.

Outline of Coverage

___ The outline of coverage must be a document separate from the policy. *211 CMR 146.10(4)*
___ The outline of coverage must be substantially similar to the one that follows; however, text that is capitalized or underlined may be emphasized by other equivalent means. *211 CMR 146.10(4)*

[CARRIER NAME]
[ADDRESS - CITY & STATE],[TELEPHONE NUMBER]

SPECIFIED DISEASE INSURANCE - OUTLINE OF COVERAGE
Policy Number:

___ **1**. This policy is [an individual policy of insurance/a group policy which was issued in (indicate jurisdiction in which group policy was issued)]. THIS IS A LIMITED POLICY.

[Except for policies or certificates that are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

___ **Caution:** The issuance of this specified disease insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue as of the date you signed the applications, the carrier has the right to deny benefits or rescind your policy subject to the [Time Limit on Certain Defenses, Incontestable] section of your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers were incorrect, contact the carrier at this address: [insert address]

___ **2. SUMMARY OF POLICY FEATURES**

This policy:

1. is not a Medicare Supplement policy.
2. [is guaranteed renewable/is noncancelable] for your lifetime.
3. [is/is not] subject to automatic premium increases as you get older.
4. [may be/is not] subject to across the board premium increases for all policyholders in your class.
5. [does/does not] offer an option to purchase inflation protection.
6. [does/does not] offer an option to purchase nonforfeiture protection.
7. [does/does not] contain special age limitations for purchase.
8. [does not cover services due to pre-existing conditions (existing health problems) for a period of __ months from policy issue][does not have a waiting period before pre-existing conditions (existing health problems) are covered].
9. [may have/has] an elimination period of __ days before benefits are payable by policy.
10. [offers a waiver of premium after __ days of __ benefits][does not offer a waiver of premium].

___ **3. PURPOSE OF OUTLINE OF COVERAGE.** An outline of coverage provides a very brief description of the important features of the coverage. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains actual contractual provisions. This means that your [policy/certificate] sets forth in detail the rights and obligations of both you and the carrier. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR [POLICY/CERTIFICATE] CAREFULLY!

___ **4. TERMS UNDER WHICH THE [POLICY/CERTIFICATE] MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

(a) [For specified disease insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable must contain the following statement:] RENEWABILITY: THIS [POLICY[/CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue this coverage as long as you pay your premiums on time. [Carrier Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

OR

(1) Policies and certificates that are noncancelable must contain the following statement:] RENEWABILITY: THIS [POLICY/CERTIFICATE] IS NONCANCELABLE. This means you have the right, subject to the terms of your policy, to continue this coverage as long as you pay your premiums on time. [Carrier Name] cannot change any of the terms of your policy on its own without your agreement, and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Carrier Name] may increase your premium at that time for those additional benefits.

OR

(1) Policies and certificates that are convertible from a group policy must contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS CONVERTIBLE TO AN INDIVIDUAL POLICY.](For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy:]

(b) [Describe waiver of premium provisions or state such provisions are not in the policy.]
(c) [State whether or not the carrier has a right to change premium, and if the right exists, describe clearly and concisely each circumstance under which premium may change, including that it is subject to the commissioner's approval.]

___ **5. TERMS UNDER WHICH THE [POLICY/CERTIFICATE] MAY BE RETURNED AND PREMIUM REFUNDED**.

(a) [Provide a brief description of the right to return—the policy's "free look" provision, which must be a minimum of ten days from the date of policy delivery.]
(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

___ **6. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the carrier.

(a) [For agents] Neither [insert carrier name] nor its agents represent Medicare, the federal government, or any state government.
(b) [For direct response] [insert carrier name] is not representing Medicare, the federal government or any state government.

___ **7. BENEFITS PROVIDED BY THIS [POLICY/CERTIFICATE].**

(a) [Covered services, deductible(s), waiting periods, elimination periods and maximums.]
___ [A policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import must include an explanation of such terms in this section of the outline of coverage.]

___ [Any benefit screening must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description.]

___ **8. LIMITATIONS AND EXCLUSIONS**

[Describe:
(a) Pre-existing conditions
(b) Non-eligible levels of care (*e.g.* unlicensed providers, care by a family member, etc.)
(c) Exclusions/exceptions
(d) Limitations]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

___ **9. RELATIONSHIP OF COST OF CARE AND BENEFITS**. Because the costs of services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;
(b) Any automatic benefit adjustment provisions;
(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by specified amount or percentage;
(d) If there is not a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
(e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

___ **10. NONFORFEITURE BENEFITS**. As an accident and sickness policy, this policy does not have a cash value associated with life insurance products. This policy may offer [for an additional charge (if applicable)] a nonforfeiture benefit that will continue until exhausted even if the policy lapses due to nonpayment of policy premiums. The following represents an example of how this benefit would apply to your policy: [As applicable, indicate the following:

___ [Carriers must include the following information in or with the outline of coverage:
(1) A description of the benefits that would accrue at different periods of policy lapse
(2) Whether or not the benefit was chosen by the policyholder.]

___ **11. PREMIUM**

[(a) State the total annual premium for the policy;
(b) If the premium varies with an applicant's choice of benefit options, indicate the portion of annual premium that corresponds to each benefit option; OR
(c) Refer individual to schedule page of the policy. For reference during the presentation, individual may be referred to policy illustration form for premium.]

___ **COMPLAINTS**. If you have a complaint, call us at ( ) ____ or your agent. If you are not satisfied, you may call or write the Massachusetts Division of Insurance.

Application Form

Application form must be in no less than 10 point type and must meet the standards of M.G.L. c. 175, §2B. *See above section on §2B and verify that the application also meets all standards.*

Is the application for a guaranteed issue policy? __ yes___ no

If no:

___ All applications and enrollment forms shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant, including information regarding the health history of the applicant. *211 CMR 146.11(1)*

___The following language must appear conspicuously near the applicant's signature block on an application:

"Caution: If your answers on this application are incorrect or untrue, [carrier] has the right to deny benefits or rescind your policy." *211 CMR 146.11(3)(a)*

___ Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider or elsewhere in the policy. Any rider that reduces benefits requires a signed acceptance by the certificateholder.

___ If an application or enrollment form contains a question that asks whether the applicant has had medication prescribed by a physician, then it must also ask the applicant to list the medication that has been prescribed and the reason that the medication was prescribed. *211 CMR 146.11(2)*

___ Application forms must ask whether as of the date of the application, the applicant and all dependents being considered for the specified disease policy are covered by a Health Plan. It should also be noted that if the applicant does not respond affirmatively to such question, the policy shall not be issued. *211 CMR 146.10(5)a. [Note: A supplementary application or other form to be signed by the applicant containing such a question may be used.]*

___ Application forms must ask whether the insurance is being applied for to replace any other policy currently in force or whether, as of the date of the application, the applicants and any dependents being considered for the specified disease policy have applications pending or policies in force for another specified disease policy or certificate for the same specified disease with the same or different insurer. If the individual has any applications pending or policies in force, the application shall ask the applicant to identify the number of policies in force and the number of pending applications for the specified disease coverage. *211 CMR 146.10(5)b. and c. [Note: A supplementary application or other form to be signed by the applicant containing such a question may be used.]*

Notices of Information Practices

Application form must conform to requirements of *M.G.L. c. 175I*:

___ *§ 4*: A notice of information practices must be provided to all applicants no later than at the time the application for insurance is made.

The notice must be in writing and must contain **EITHER**:
___whether personal information may be collected from persons other than the individual proposed for coverage; *M.G.L. c. 175I § 4(b)(1)*
___the type of personal information that may be collected and the type of source and investigative technique that may be used to collect such information; *M.G.L. c. 175I § 4(b)(2)*
___the type of disclosure permitted by chapter 175I and the circumstances under which such disclosure may be made without prior authorization: provided, however, that only such circumstances need be described which occur with such frequency as to indicate a general business practice; *M.G.L. c. 175I § 4(b)(3)*
___a description of the rights established under sections eight, nine and ten and the manner in which such rights may be exercised: *M.G.L. c. 175I § 4(b)(4)*
___ *§ 8* describes the right of an individual to obtain any personal information collected or maintained by the insurer upon written request, including any persons to whom the insurer has disclosed the information, and procedures by which such information may be corrected, amended, or deleted.
___ *§ 9* describes the right of an individual to have factual errors corrected and any misrepresentation or misleading information amended or deleted upon written request.
___ *§ 10* describes the right of an individual to receive the specific reason for an adverse underwriting decision in writing.
___that information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons. *M.G.L. c. 175I § 4(b)(5)*

OR

___ an abbreviated notice may be used that informs the applicant that:
___ personal information may be collected from a person other than the individual proposed for coverage; *§ 4(c)(1)*
___ such information as well as other personal or privileged information subsequently collected by the insurance institution or insurance representative may in certain circumstances be disclosed to a third party without authorization; *M.G.L. c. 175I § 4(c)(2)*
___ a right of access and correction exists with respect to all personal information collected; *§ 4(c)(3)*
___ the more detailed notices described above will be furnished to the applicant upon request. *§ (4)(c)(4)*

___ *§ 6*: A disclosure authorization is to be included with the application and:

___ 1. is written in plain language
___ 2. is dated
___ 3. specifies the types of persons authorized to disclose information about the individual
___ 4. specifies the nature of the information to be disclosed
___ 5. names the insurance company and identifies by generic reference the person to whom the applicant is authorizing information to be disclosed.
___ 6. specifies the purposes for which the information is collected.
___ 7. specifies that the authorization shall be valid for no longer than thirty months from the time it is signed
___ 8. advises the applicant that s/he is entitled to receive a copy of the authorization form.

Replacement Notice

___ A replacement notice, to be supplied to the applicant who indicates that the sale would involve replacement of another policy, must be submitted for review.

___ The replacement notice must be substantially the same as the following: *(211 CMR 42.99)*

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by ___ Insurance Company. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new policy.

1. Health conditions which you may presently have, may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is your right, under the policy you have chosen.

The above "Notice to Applicant" was delivered to me on (date).

_____ Applicant